IMS
INTERNAL MEDICINE SPECIALISTS

Thomas A. Alfreda. Jr., MBA., D.O.
Babak Ghadishah, D.O.
Gary J. Grossman, M.D.
Robert A. Whipple, M.D.
Misako McLeod, DPM
Faezah Izadmanesh, M.D.
David H. Rosenstein, M.D.

201 North Buffalo Drive
Las Vegas, Nevada 89145-0373

Telephone: 702.242.2737
Fax: 702.255.3170

www.IMSDoctors.com

PATIENT INFORMATION

Name: _____

Date of Birth: _____ SSN: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Referring Doctor: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone _____ Email: _____

Preferred method of communication? _____

Home phone: Okay to leave a message? ☐ YES ☐ NO

Cell phone: Okay to leave a message? ☐ YES ☐ NO

Email: _____ Other:

GUARANTOR INFORMATION†

Name of Responsible Party: _____

Date of Birth: _____ SSN: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Relationship to Responsible Party: ☐ Dependent ☐ Spouse ☐ Other: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

†If the primary insurance is through the parent/spouse, please complete this using their information

CONTINUED ON NEXT PAGE

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EMERGENCY CONTACT

Name: _____ Relation: _____

Phone: _____ Email: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Certificate Number: _____ Certificate Number: _____

Group Number: _____ Group Number: _____

Group Name: _____ Group Name: _____

Co-pay: $_____ Co-pay: $ _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber DOB: _____

How did you hear about us? _____

☐ Friend: Who shall we thank? _____

☐ Doctor: Who shall we thank? _____

☐ Hospital ☐ Advertisement ☐ Website Which? _____

☐ ZocDoc: _____ ☐ Other: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I authorize the release or medical or other information as necessary to process health insurance claims. I also request payment of benefits to my Provider when he/she accepts assignment.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

There will be a service fee of .60¢ per page for medical records forwarded to a lawyer, insurance company or directly to the patient. We will, however, transfer medical records to another physician at no cost.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize my Provider to release any information necessary for the course of treatment.

DATE: _____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: ____/____/____

RELEASE THE FOLLOWING RECORDS TO:

Internal Medicine Specialists
201 N. Buffalo Drive
Las Vegas, NV 89145
TEL (702) 242-2737 • FAX (702)255-3170

RELEASE THE FOLLOWING RECORDS FROM:

ORGANIZATION'S NAME: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

☐ Entire Health Records ☐ EKG
☐ History & Physical ☐ Lab Results
☐ Blood Sugar Results ☐ Prescription List

Patient Signature: _____ Date: _____

If patient is a minor, please sign by parent or custodial agent If signed by representative, relationship to patient: _____ Date: _____

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INSURANCE AND FINANCIAL RESPONSIBILITY

We are thankful you have chosen our practice for your healthcare needs, but please be aware that medical insurance is a contract between you and your insurance provider and that YOU are ultimately responsible for payment of our services.

Your Co-pay/co-insurance/medical deductible amount is due and payable at the time of your visit

We are happy to bill your insurance company if we are a provider on your plan, however, we ask for your help in ensuring no interruption of care:

- Understand your deductible and co-pay amounts and be prepared to pay that amount at your visit
- Check with your insurance company to determine if authorization is required for any testing
- Find out which diagnostic facilities are allowed to provide treatment

I have read and understood that billing to my insurance is provided as a courtesy and that I am ultimately responsible for payment of my medical bill.

Patient Name:_____ Date: _____

Patient Signature: _____

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MEDICAL HISTORY

TODAY'S DATE:_____

NAME:_____

SOCIAL SECURITY NUMBER:_____

OCCUPATION:_____ EMPLOYER:_____

DATE OF BIRTH:_____ AGE:_____ SEX: M F

ALLERGIES

NAME OF DRUG OR TYPE OF ALLERGY	REACTION	OUTCOME?

CURRENT MEDICATIONS

MEDICATION	DOSAGE	MEDICATION	DOSAGE

PREVIOUS HOSPITALIZATIONS/SURGERIES

YEAR	HOSPITAL/CITY	REASON	PHYSICIAN

PAST MEDICAL HISTORY

PLEASE INDICATE WHETHER YOU HAVE EVER HAD ANY OF THE FOLLOWING:

YES	NO	CONDITION	YES	NO	CONDITION
		High Blood Pressure			Asthma
		Heart Attack / MI			Kidney Stones
		Diabetes			Kidney Disease
		Stomach Ulcers			Pneumonia
		Gout			Arthritis
		Liver Disease / Hepatitis			Gallbladder Disease
		Thyroid Disease			Anemia
		Psoriasis			Increased Cholesterol
		Cancer			Blood Transfusion
		Stroke			History Of Heart Murmur
		Accident / Broken Bones (List)			

OTHER SIGNIFICANT PROBLEMS. Describe any medical condition not listed:

_____

_____

FEMALES ONLY Are you pregnant? ☐YES ☐NO Could you possibly be pregnant? ☐YES ☐NO

Date of last menstrual period: _____/_____/_____

CONTINUED ON NEXT PAGE

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FAMILY HISTORY

Has anyone in your family ever had the following?

YES	NO	CONDITION	RELATIONSHIP	YES	NO	CONDITION	RELATIONSHIP
		Heart Disease	☐Mother ☐Father ☐Other:			Diabetes	☐Mother ☐Father ☐Other:
		Epilepsy	☐Mother ☐Father ☐Other:			Thyroid Disease	☐Mother ☐Father ☐Other:
		Stroke	☐Mother ☐Father ☐Other:			Cancer	☐Mother ☐Father ☐Other:
		Asthma	☐Mother ☐Father ☐Other:			High Blood Pressure	☐Mother ☐Father ☐Other:
		Bleeding Tendencies	☐Mother ☐Father ☐Other:			Other:	☐Mother ☐Father ☐Other:

MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SINGLE **IS YOUR SPOUSE:** ☐ ALIVE ☐ DECEASED

HABITS

Do you now or have you ever smoked?	YES	NO	How much/many?	How long?
Do you drink alcohol?	YES	NO	How much?	How long?
Do you use recreational drugs (e.g., marijuana)?	YES	NO	How much/many?	How long?

SYSTEM REVIEW

Please check any problems which apply to you at this time

GENERAL
☐ Weakness
☐ Fatigue
☐ Fever
☐ Recent Weight Gain
☐ Recent Weight Loss

CARDIOVASCULAR
☐ Chest pain or tightness
☐ Irregular Heartbeat
☐ Heart Murmur
☐ Passing Out

GENITOURINARY
☐ Incontinence or urine
☐ Difficulty or Burning Urination
☐ Blood in Urine
☐ Discharge (penis)
☐ Prostate trouble

EYES
☐ Blurred vision
☐ Double vision
☐ Eye drainage
☐ Eye redness
☐ Eye exam

LUNGS
☐ Shortness of breath
☐ Cough
☐ Difficulty breathing
☐ Coughing of blood
☐ Wheezing

GYNECOLOGICAL (female)
☐ Vaginal dryness
☐ Vaginal bleeding
☐ Last menstrual period:
_____/_____/_____

DERMATOLOGICAL
☐ Skin rash
☐ Acne
☐ Skin itching
☐ Moles

MUSCLES/JOINTS
☐ Morning stiffness
How long? Minutes:_____
Hours:_____
☐ Joint swelling/Pain
☐ Joints affected:
_____
☐ Muscle spasm

HEAD/EARS/NOSE & THROAT
☐ Headache
☐ Ear pain
☐ Ear drainage
☐ Decreased hearing
☐ Nasal congestion
☐ Throat pain
☐ Hoarseness of voice
☐ Change in voice

GASTROINTESTINAL
☐ Nausea
☐ Vomiting of blood or coffee material
☐ Yellow jaundice
☐ Blood in stool
☐ Black stool
☐ Heartburn

NEUROLOGICAL
☐ Weakness (either side of body)
☐ Right:_____
☐ Left:_____
☐ Headaches
☐ Dizziness
☐ Fainting
☐ Memory Loss

ENDOCRINE
☐ Dry skin
☐ Coarse hair
☐ Early menstrual flow
☐ Cold/Heat intolerance

SCREENING PROCEDURES

Date of last treadmill? _____/_____/_____
Date of last EKG? _____/_____/_____
Date of last sigmoid/colonoscopy? _____/_____/_____
Date of last chest x-ray? _____/_____/_____
Date of last blood work? _____/_____/_____
Date of last Dexascan? _____/_____/_____

FEMALES ONLY

Date of last pap smear? _____/_____/_____
Date of last mammogram? _____/_____/_____

MedHx
updated July, 2013

I certify that the above information is true and accurate.

Patient's signature: _____ Date: _____

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ADVANCE CARE PLANNING
(Advance Directives)
PATIENTS 18 YEARS OF AGE AND OLDER

Advance Care Planning refers to a process of mapping out the types of medical and non-medical care you would like to receive at some future point should a life-threatening or terminal disease make it impossible for you to express your wishes at that time. This type of planning is an ongoing process. It is a process of thoughtful discussion between you and your care providers, spouse, family, and significant others.

While this conversation often results in a document, it is more than just a piece of paper. It is an effort to better educate yourself about alternatives regarding the end-of-life and an opportunity to education your physician, spouse, family and others about your values, goals and wishes related to end-of-life care.

This communication between you and your healthcare provider can be done at any time, preferably when you are younger and still healthy. Once complete, it should be revisited on a regular basis — every five years or after any potentially life-changing event such as marriage, divorce, death of a spouse or the onset of a life-threatening disease.

Advance Care Planning usually produces an Advance Directive, which is a written document that helps to summarize the plans you have made for future care. These documents take several forms, such as Living Will and a Durable Power of Attorney for Health Care. While they can be completed without the involvement of your healthcare provider, it is much preferred to do this together. The future usefulness of these documents is better assured if your healthcare professional has been part of the planning process.

Please check one of the statements and sign below.

☐ I have an Advance Directive in effect and agree to provide a copy for my medical record.

☐ I do NOT currently have an Advance Directive in effect. I have read and understand the information above on Advance Directives.

Patient Name: _____ Date: _____

Patient Signature: _____

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RELEASE OF PERSONAL RECORDS

I, _____, hereby give my permission to Internal Medicine Specialists of Southern Nevada to release any information pertaining to me to:

_____

(Name of spouse, family or legal guardian).

Relation to patient:_____

Address: _____

City:_____ State:_____ Zip: _____

Email:_____

Printed patient's name: _____

Signed this _____ day of _____, 20_____

Signature: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Informational Uses and Disclosures of Protected Health Informational Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing healthcare services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

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HIPAA NOTICE OF PRIVACY PRACTICES (CONTINUED)

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated by this authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Office Administrator/HIPAA Compliance Officer in person or by phone at (702) 242-2737.

By signing below, you are only acknowledging you have received this Notice of Privacy Practices

Patient Name: _____ Date: _____

Patient Signature: _____